FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037002

Facility Name: Lexington of Streamwood

Address: 815 E. Irving Park Road (Number) Streamwood (City) 60107 (Zip Code)

County: Cook

Telephone Number: (630) 837-5300 **Fax #** (630) 213-9076

IDPA ID Number: 363748803001

Date of Initial License for Current Owners: 07/08/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,760	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,760	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,802	3,284	11,031	37,117	8
9	SNF/PED					9
10	ICF	24,313	2,245	341	26,899	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,115	5,529	11,372	64,016	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.30%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/08/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 6,655

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	299,897	29,039	15,732	344,668		344,668		344,668			1
2	Food Purchase		255,574		255,574		255,574	(11,217)	244,357			2
3	Housekeeping	255,800	42,446		298,246		298,246	771	299,017			3
4	Laundry	70,297	24,093		94,390		94,390	(5,392)	88,998			4
5	Heat and Other Utilities			192,264	192,264		192,264	4,117	196,381			5
6	Maintenance	70,669		118,091	188,760		188,760	1,599	190,359			6
7	Other (specify):*											7
8	**TOTAL General Services**	696,663	351,152	326,087	1,373,902		1,373,902	(10,122)	1,363,780			8
	B. Health Care and Programs											
9	Medical Director			24,500	24,500		24,500		24,500			9
10	Nursing and Medical Records	3,009,596	314,690	131,341	3,455,627		3,455,627		3,455,627			10
10a	Therapy			642,078	642,078		642,078		642,078			10a
11	Activities	224,184	14,229	3,384	241,797		241,797		241,797			11
12	Social Services	77,307		12,257	89,564		89,564		89,564			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,311,087	328,919	813,560	4,453,566		4,453,566		4,453,566			16
	C. General Administration											
17	Administrative	195,967		381,460	577,427		577,427	(381,460)	195,967			17
18	Directors Fees											18
19	Professional Services			52,675	52,675		52,675	5,398	58,073			19
20	Dues, Fees, Subscriptions & Promotions			31,368	31,368		31,368	1,179	32,547			20
21	Clerical & General Office Expenses	477,104	36,420	38,539	552,063		552,063	14,681	566,744			21
22	Employee Benefits & Payroll Taxes			593,586	593,586		593,586	71,745	665,331			22
23	Inservice Training & Education			738	738		738		738			23
24	Travel and Seminar			3,312	3,312		3,312	3,232	6,544			24
25	Other Admin. Staff Transportation							10,600	10,600			25
26	Insurance-Prop.Liab.Malpractice			174,711	174,711		174,711	3,522	178,233			26
27	Other (specify):*											27
28	**TOTAL General Administration**	673,071	36,420	1,276,389	1,985,880		1,985,880	(271,103)	1,714,777			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,680,821	716,491	2,416,036	7,813,348		7,813,348	(281,225)	7,532,123			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of Streamwood #0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			57,482	57,482		57,482	183,680	241,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,695	15,695		15,695	333,084	348,779			32
33	Real Estate Taxes							430,861	430,861			33
34	Rent-Facility & Grounds			1,619,417	1,619,417		1,619,417	(1,619,417)				34
35	Rent-Equipment & Vehicles			1,829	1,829		1,829	4,868	6,697			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,694,423	1,694,423		1,694,423	(666,924)	1,027,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		146,252	117,169	263,421		263,421		263,421			39
40	Barber and Beauty Shops			18,195	18,195		18,195		18,195			40
41	Coffee and Gift Shops			9,315	9,315		9,315		9,315			41
42	Provider Participation Fee			122,640	122,640		122,640		122,640			42
43	Other (specify):* Nonallowable Costs			42,273	42,273		42,273	(42,273)				43
44	**TOTAL Special Cost Centers**		146,252	309,592	455,844		455,844	(42,273)	413,571			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,680,821	862,743	4,420,051	9,963,615		9,963,615	(990,422)	8,973,193			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(52)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(5,392)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(480)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(968)	43		13
14	Non-Care Related Interest	(9,729)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,909)	43		24
25	Fund Raising, Advertising and Promotional	(15,371)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	80	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(548,141)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (605,987)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(384,435)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (384,435)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (990,422)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Streamwood

ID# 0037002

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/02 - 12/31/02 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Amortized deferred maintenance	465	6
Nonallowable collections and out of period legal fees	(9,431)	19
Nonallowable Chamber of commerce dues	(870)	20
Offset miscellaneous income	(856)	21
Miscellaneous nonallowable expenses	(10,983)	21
Unrealized loss on fair value of an interest rate swap	(526,466)	43
Total	(548,141)	

See Accountants' Compilation Report

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(52)	0	0	0	0	0	0	0	0	0	0	(52)	2
3	Housekeeping	0	0	771	0	0	0	0	0	0	0	0	771	3
4	Laundry	(5,392)	0	0	0	0	0	0	0	0	0	0	(5,392)	4
5	Heat and Other Utilities	0	0	4,117	0	0	0	0	0	0	0	0	4,117	5
6	Maintenance	0	0	1,134	0	0	0	0	0	0	0	0	1,134	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,444)	0	6,022	0	0	0	0	0	0	0	0	578	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(381,460)	0	0	0	0	0	0	0	(381,460)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,279	10,680	0	0	0	0	0	0	0	0	23,959	19
20	Fees, Subscriptions & Promotions	0	0	2,049	0	0	0	0	0	0	0	0	2,049	20
21	Clerical & General Office Expenses	0	1,234	25,286	0	0	0	0	0	0	0	0	26,520	21
22	Employee Benefits & Payroll Taxes	0	0	60,580	0	0	0	0	0	0	0	0	60,580	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,232	0	0	0	0	0	0	0	0	3,232	24
25	Other Admin. Staff Transportation	0	0	0	10,600	0	0	0	0	0	0	0	10,600	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,522	0	0	0	0	0	0	0	3,522	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	14,513	101,827	(367,338)	0	0	0	0	0	0	0	(250,998)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,444)	14,513	107,849	(367,338)	0	0	0	0	0	0	0	(250,420)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Streamwood # 0037002 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	155,124	0	28,556	0	0	0	0	0	0	0	183,680	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,209)	338,672	0	4,621	0	0	0	0	0	0	0	333,084	32
33	Real Estate Taxes	0	419,417	0	2,314	0	0	0	0	0	0	0	421,731	33
34	Rent-Facility & Grounds	0	(1,619,417)	0	0	0	0	0	0	0	0	0	(1,619,417)	34
35	Rent-Equipment & Vehicles	0	0	0	4,868	0	0	0	0	0	0	0	4,868	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,209)	(706,204)	0	40,359	0	0	0	0	0	0	0	(676,054)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(42,193)	526,386	0	0	0	0	0	0	0	0	0	484,193	43
44	**TOTAL Special Cost Centers**	(42,193)	526,386	0	0	0	0	0	0	0	0	0	484,193	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(57,846)	(165,305)	107,849	(326,979)	0	0	0	0	0	0	0	(442,281)	45

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Streamwood Limited Partnership	Streamwood	Real estate ptsp.
				Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Sambell of Streamwood Limited Partnership	**	$ 13,279	$ 13,279	1
2	V	21	Office supplies expense		Sambell of Streamwood Limited Partnership	**	1,134	1,134	2
3	V	21	Bank charges		Sambell of Streamwood Limited Partnership	**	100	100	3
4	V	30	Depreciation		Sambell of Streamwood Limited Partnership	**	155,124	155,124	4
5	V	32	Interest expense		Sambell of Streamwood Limited Partnership	**	333,704	333,704	5
6	V	32	Amortization of mortgage costs		Sambell of Streamwood Limited Partnership	**	4,968	4,968	6
7	V	33	Property taxes		Sambell of Streamwood Limited Partnership	**	419,417	419,417	7
8	V	34	Rental expense	1,619,417	Sambell of Streamwood Limited Partnership	**		(1,619,417)	8
9	V	43	State replacement tax		Sambell of Streamwood Limited Partnership	**	(80)	(80)	9
10	V	43	Unrealized loss on fmv of interest rate swap		Sambell of Streamwood Limited Partnership	**	526,466	526,466	10
11	V								11
12	V		**The owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Sambell of Streamwood Limited Partnership						12
13	V								13
14	Total			$ 1,619,417			$ 1,454,112	$ * (165,305)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 771	$ 771	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,921	3,921	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	196	196	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	1,068	1,068	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	49	49	19
20	V	6	Security service		Royal Management Corp.	**	17	17	20
21	V	19	Computer consultant & supplies		Royal Management Corp.	**	8,509	8,509	21
22	V	19	Professional fees		Royal Management Corp.	**	2,171	2,171	22
23	V	20	Advertising - help wanted		Royal Management Corp.	**	1,232	1,232	23
24	V	20	Dues & subscriptions		Royal Management Corp.	**	817	817	24
25	V	21	Bank charges		Royal Management Corp.	**	2,839	2,839	25
26	V	21	Communications		Royal Management Corp.	**	567	567	26
27	V	21	Office supplies & printing		Royal Management Corp.	**	10,757	10,757	27
28	V	21	Postage		Royal Management Corp.	**	3,379	3,379	28
29	V	21	Telephone		Royal Management Corp.	**	7,744	7,744	29
30	V	22	FICA		Royal Management Corp.	**	32,654	32,654	30
31	V	22	FUTA		Royal Management Corp.	**	601	601	31
32	V	22	SUTA		Royal Management Corp.	**	655	655	32
33	V	22	Insurance - W/C		Royal Management Corp.	**	757	757	33
34	V	22	Insurance - hospitalization		Royal Management Corp.	**	18,994	18,994	34
35	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	6,919	6,919	35
36	V	24	Travel & seminar		Royal Management Corp.	**	3,232	3,232	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 107,849	$ * 107,849	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 10,600	$ 10,600	15
16	V	26	Insurance - general		Royal Management Corp.	**	3,522	3,522	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,781	3,781	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,425	7,425	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	17,350	17,350	19
20	V	32	Interest		Royal Management Corp.	**	4,621	4,621	20
21	V	33	Property taxes		Royal Management Corp.	**	2,314	2,314	21
22	V	35	Equipment rental		Royal Management Corp.	**	4,868	4,868	22
23	V	17	Management fees	381,460	Royal Management Corp.	**		(381,460)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Streamwood, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 381,460			$ 54,481	$ * (326,979)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule B**
1/1/02 - 12/31/02

VII. Related Parties

Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Related Nursing Homes	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	5	11.00%	Salary	$ 39,901	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	10.00%	Salary	17,734	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	10.00%	Salary	22,167	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10.00%	Salary	5,320	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12.00%	Salary	13,437	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week					8
9											9
10											10
11											11
12											12
13								TOTAL	$ 98,559		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule C**
1/1/02 - 12/31/02

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
Total	142,266	320,099	177,833	42,680	107,794	790,672

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 6,954	$	81,760	$ 771	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380		81,760	3,921	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765		81,760	196	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640		81,760	1,068	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438		81,760	49	5
6	6	Security service	Bed Days	737,665	10	150		81,760	17	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767		81,760	8,509	7
8	19	Professional fees	Bed Days	737,665	10	19,590		81,760	2,171	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111		81,760	1,232	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373		81,760	817	10
11	21	Bank charges	Bed Days	737,665	10	25,613		81,760	2,839	11
12	21	Communications	Bed Days	737,665	10	5,118		81,760	567	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051		81,760	10,757	13
14	21	Postage	Bed Days	737,665	10	30,484		81,760	3,379	14
15	21	Telephone	Bed Days	737,665	10	69,873		81,760	7,744	15
16	22	FICA	Bed Days	737,665	10	294,613		81,760	32,654	16
17	22	FUTA	Bed Days	737,665	10	5,419		81,760	601	17
18	22	SUTA	Bed Days	737,665	10	5,907		81,760	655	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829		81,760	757	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371		81,760	18,994	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427		81,760	6,919	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161		81,760	3,232	22
23										23
24										24
25	TOTALS					$ 973,034	$		$ 107,849	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 95,636	$	81,760	$ 10,600	1
2	26	Insurance - general	Bed Days	737,665	10	31,776		81,760	3,522	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112		81,760	3,781	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995		81,760	7,425	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541		81,760	17,350	5
6	32	Interest	Bed Days	737,665	10	41,692		81,760	4,621	6
7	33	Property taxes	Bed Days	737,665	10	20,881		81,760	2,314	7
8	35	Equipment rental	Bed Days	737,665	10	43,917		81,760	4,868	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 491,550	$		$ 54,481	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	x		Mortgage	Varies	2/01/96	5,985,000	5,028,750	02/01/2026	Variable	333,704	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	x		Working capital	None	Various	1,154,048	391,592	Demand	0.0300	11,000	6
7	LaSalle Bank N.A.		x	Working capital	None	04/06/02	700,000	300,000	04/06/2003	0.0425	4,695	7
8												8
9	TOTAL Facility Related						$ 7,839,048	$ 5,720,342			$ 349,399	9
	B. Non-Facility Related*											
10							Amortization of mortgage costs				4,968	10
11							Interest income offset				(480)	11
12							Non-allowable interest				(9,729)	12
13							Allocated from management company				4,621	13
14	TOTAL Non-Facility Related						$	$			$ (620)	14
15	TOTALS (line 9+line14)						$ 7,839,048	$ 5,720,342			$ 348,779	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$	480,000	1
Allocated from management company			2,314	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$	438,043	2
3. Under or (over) accrual (line 2 minus line 1).		$	(39,643)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	462,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	9,130	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 626 For 1995 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	(626)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	430,861	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	438,787	8
	1998	445,743	9
	1999	448,359	10
	2000	454,959	11
	2001	438,043	12

2001 taxes:	438,043
Estimated increase:	1.055
Estimated taxes:	462,135
Use:	462,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Streamwooc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037002

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4796

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-300-006-0000	Land & Building	$ 438,042.99	$ 438,042.99
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land & Building	$ 70,162.04	$ 162.00
4.	Royal Management Corp. (Samvest		$	$
5.	05-01-202-019	Land & Building	$ 144,399.48	$ 2,152.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 652,604.51	$ 440,356.99

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,942 B. General Construction Type: Exterior Concrete block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	30,000	1991	$ 211,400	1
2	Mgmt Co.		2002	18,045	2
3	TOTALS	30,000		$ 229,445	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1991	1,991	$ 5,248,322	$	35	$ 149,952	$ 149,952	$ 1,724,449	4
5	10		1993	1,993	105,236		35	3,007	3,007	25,557	5
6	14		1995	1,995	82,650	2,361	35	2,361		17,710	6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	7,336		35	210	210	1,995	9
10	Land Improvements			1995	7,000	467	15	467		3,501	10
11	Kitchen & Nurses Station			1996	12,316	352	35	352		2,288	11
12	Piping			1996	3,139	90	35	90		584	12
13	Basement remodeling			1997	20,204	2,020	10	2,020		10,774	13
14	Floor Repairs			1997	555	56	10	56		284	14
15	Corner Guards			1997	998	100	10	100		508	15
16	Corner Guards			1998	3,563	356	10	356		1,602	16
17	Wiring			1998	2,050	205	10	205		923	17
18	Tile			1998	11,696	1,170	10	1,170		4,680	18
19	Patio			1999	12,011	801	15	801		2,470	19
20	Parking lot			2000	1,773	177	10	177		443	20
21	110-ton A/C Unit			2000	6,922	692	10	692		1,730	21
22	Rods for bedside curtains			2000	5,872	587	10	587		1,175	22
23	Automatic Doors			2000	1,300	130	10	130		325	23
24	Rehab project: carpeting, wallcovering, handrails, painting			2000	85,196	8,519	10	8,519		21,298	24
25	Compressor / tube bundles-cooling system			2001	12,922	1,292	10	1,292		1,938	25
26	Rehab project: resident rooms, corridors, dining room			2001	212,217	10,611	20	10,611		15,916	26
27	Parking lot			2002	29,288	1,464	10	1,464		1,464	27
28	Office area rehab			2002	26,991	675	20	675		675	28
29	Elevator interior upgrade			2002	1,120	65	10	65		65	29
30	Gazebo			2002	3,393	170	10	170		170	30
31	Elevator electronic curtains			2002	4,500	412	10	412		412	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 11,437	$	35	$ 415	$ 415	$ 2,451	37
38	Leasehold improvements - management company	1996	9,308		35	338	338	1,729	38
39	Leasehold improvements - management company	1989	321		31	12	12	151	39
40	HVAC - management company	1998	241		35	9	9	34	40
41	Offices - management company	1999	608		35	22	22	61	41
42	Offices - management company	2000	289		35	10	10	23	42
43	Land improvements - management company	2002	10,824		15	661	661	661	43
44	Building - management company	2002	252,340		40	5,783	5,783	5,783	44
45	Sewer & water improvements - management company	2002	5,740		30	175	175	175	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,199,678	$ 32,772		$ 193,366	$ 160,594	$ 1,854,004	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 204,609	$ 22,367	$ 24,322	$ 1,955	5-10 years	$ 145,398	71
72	Current Year Purchases	32,828	2,343	2,343		5-10 years	2,343	72
73	Fully Depreciated Assets	373,951					373,951	73
74	Allocated from Mgmt. Co.	173,290		17,350	17,350		45,327	74
75	TOTALS	$ 784,678	$ 24,710	$ 44,015	$ 19,305		$ 567,019	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			33,843		3,781	3,781		23,551	79
80	TOTALS			$ 33,843	$	$ 3,781	$ 3,781		$ 23,551	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,247,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,482	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 241,162	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 183,680	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,444,574	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 6,697 Description: Copier: $1,280; Postage meter: $549; Allocated from Management Company: $4,868
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	19,578	$ 294,888	$	19,578	$ 294,888	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,178	51,653		3,178	51,653	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		28,659	295,537		28,659	295,537	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				146,252		146,252	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					117,169			117,169	13
14	TOTAL			$	51,415	$ 759,247	$ 146,252	51,415	$ 905,499	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Streamwood
Provider #: 0037002
01/01/02 to 12/31/02

Schedule 16A

Schedule XIV. Special Services
Line 13, Other

Service	Cost	Line Reference
Clinitron Beds	34,074	L 39, C 3
Oxygen	73,695	L 39, C 3
Laboratory	2,638	L 39, C 3
Radiology	6,762	L 39, C 3
Total	117,169	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 113,055	$ 140,032	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 460,657)	1,994,084	1,994,084	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,915	63,915	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	69,032	68,039	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,240,086	$ 2,266,070	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	56,718	56,718	12
13	Land		229,445	13
14	Buildings, at Historical Cost		5,353,558	14
15	Leasehold Improvements, at Historical Cost	547,676	846,120	15
16	Equipment, at Historical Cost	222,614	818,521	16
17	Accumulated Depreciation (book methods)	(221,774)	(2,444,574)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs		92,967	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 605,234	$ 4,952,755	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,845,320	$ 7,218,825	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 311,367	$ 311,367	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	439,997	439,997	28
29	Short-Term Notes Payable	391,592	391,592	29
30	Accrued Salaries Payable	319,724	319,724	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,999	1,999	31
32	Accrued Real Estate Taxes(Sch.IX-B)		462,000	32
33	Accrued Interest Payable		40,964	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	724,437	93,075	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,189,116	$ 2,060,718	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	300,000	300,000	39
40	Mortgage Payable		5,028,750	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest rate swap liability		526,466	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 300,000	$ 5,855,216	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,489,116	$ 7,915,934	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 356,204	$ (697,109)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,845,320	$ 7,218,825	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002
1/1/02 - 12/31/02 **Schedule E**

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	631,362	-
Accrued management fees	23,217	23,217
Accrued 401 (k) contribution	17,132	17,132
Other accrued expenses	52,726	52,726
Total line 36	724,437	93,075

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous Income	856
Investment Income in Lexington Financial Services, LLC	791
Bedhold Income	1,710
Total line 28	3,357

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 990,638	1	
2	Restatements (describe):		2	
3	**Prior period adjustment**	(114,093)	3	
4	**Prior year post closing entries**	46,637	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 923,182	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(566,978)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (566,978)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 356,204	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,421,581	1
2	Discounts and Allowances for all Levels	(481,579)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,940,002	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,092,202	6
7	Oxygen	2,639	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,094,841	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	10,022	12
13	Barber and Beauty Care	21,945	13
14	Non-Patient Meals	52	14
15	Telephone, Television and Radio	91	15
16	Rental of Facility Space		16
17	Sale of Drugs	206,886	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,302	19
20	Radiology and X-Ray	8,294	20
21	Other Medical Services	75,973	21
22	Laundry	5,392	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 357,957	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	480	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 480	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	3,357	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,357	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,396,637	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,373,902	31
32	Health Care	4,453,566	32
33	General Administration	1,985,880	33
	B. Capital Expense		
34	Ownership	1,694,423	34
	C. Ancillary Expense		
35	Special Cost Centers	333,204	35
36	Provider Participation Fee	122,640	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,963,615	40
41	**Income before Income Taxes (line 30 minus line 40)****	(566,978)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (566,978)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,028	2,084	$ 79,926	$ 38.35	1
2	Assistant Director of Nursing	3,809	4,009	111,845	27.90	2
3	Registered Nurses	46,473	49,932	1,325,697	26.55	3
4	Licensed Practical Nurses	14,786	15,568	355,050	22.81	4
5	Nurse Aides & Orderlies	86,234	89,953	1,036,042	11.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,241	7,930	101,036	12.74	8
9	Activity Director	1,894	2,096	41,500	19.80	9
10	Activity Assistants	19,401	20,234	182,684	9.03	10
11	Social Service Workers	4,138	4,255	77,307	18.17	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,059	27,761	13.48	13
14	Head Cook	1,933	2,059	28,168	13.68	14
15	Cook Helpers/Assistants	12,358	13,185	125,072	9.49	15
16	Dishwashers	17,613	18,584	118,896	6.40	16
17	Maintenance Workers	4,347	4,677	70,669	15.11	17
18	Housekeepers	35,956	38,180	255,800	6.70	18
19	Laundry	10,464	11,118	70,297	6.32	19
20	Administrator	2,056	2,199	97,408	44.30	20
21	Assistant Administrator					21
22	Other Administrative	737	737	98,559	133.73	22
23	Office Manager					23
24	Clerical	25,156	27,203	477,104	17.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	298,541	316,062	$ 4,680,821 *	$ 14.81	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	220	$ 15,732	L1, C3	35
36	Medical Director	Monthly	24,500	L9, C3	36
37	Medical Records Consultant	21	1,050	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,384	L11, C3	44
45	Social Service Consultant	260	12,257	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	501	$ 58,123		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,627	$ 64,364	L10, C3	50
51	Licensed Practical Nurses	252	5,578	L10, C3	51
52	Nurse Aides	3,298	54,418	L10, C3	52
53	TOTAL (lines 50 - 52)	6,177	$ 124,360		53

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chris Anderson	Administrator	0.00%	$ 97,408
John Samatas	Admin/Plant Ops	22.33%	17,734
James Samatas	Administrative	22.33%	39,901
Cynthia Thiem	Administrative	22.34%	22,167
George Samatas	Administrative	0.00%	5,320
Jason Samatas	Administrative	0.00%	13,437
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 195,967

B. Administrative - Other

Description	Amount
Management fees (elimnated in column 7)	$ 381,460
TOTAL (agree to Schedule V, line 17, col. 3)	$ 381,460
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) Administration	$ 510
Altschuler, Melvoin & Glasser, LLP	Accounting	20,347
American Express Tax & Bus. Svcs.	Accounting	5,313
Internet Presence Consulting	Computer Consulting	711
Harris, Kessler & Goldstein	Legal	2,589
Freedman, Anselmo & Lindberg	Legal-collections	9,431
Personnel Planners	U/C Consulting	1,395
Katten, Muchin Zavis & Rosenman	Legal	868
Systematic Management Systems	Billing Consultant	99
James Samatas	Legal	73
See attached Schedule F		11,339
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 52,675

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,926
Unemployment Compensation Insurance	22,872
FICA Taxes	344,859
Employee Health Insurance	130,208
Employee Meals	11,165
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	20,507
CNA Transportation	40,590
Other Employee Benefits	11,204
TOTAL (agree to Schedule V, line 22, col.8)	$ 665,331

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	28,504
Health Care Worker Background Check	
(Indicate # of checks performed 30)	366
Miscellaneous Licenses, Permits	819
Miscellaneous Dues & Subs	1,641
Allocated from management company	817
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,547

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,312
Allocated from management company	3,232
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,544

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Streamwood, Inc.
Provider # 0037002 **Schedule F**
1/1/02 - 12/31/02

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	5,580
Carol Jeschke	Staffing consultant	739
Glantz - Richman	Rehabilitation consultant	350
Advanced Answers on Demand	Computer consulting	3,247
Action Computer Services	Computer consulting	324
Gigatrend	Computer consulting	195
Tricom Computer	Computer consulting	37
Information Controls, Inc.	Computer consulting	867
		11,339
Total, Agrees to Schedule V, Line 19, Column 3		52,675
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/		
American Express Tax & Business Services	Accounting	808
Brekke Consulting, Inc.	Exec. Counsel Consulting	187
Gilson, Labus and Silverman	Accounting	50
James Samatas	Legal	22
Katten, Muchin, Zavis and Rosenman	Legal	245
Sachnoff and Weaver	Legal	134
ING / Pension Administrators / Aetna Life Insurance & A	401 (k) Administration	600
Various	Consulting	125
Various	Computer Consulting	8,509
Allocated from building partnership		
James Samatas	Filing and recording fees	149
McCracken, Walsh, DeLavan & Hetler	Real estate tax appeal fees	9,130
LaSalle Appraisal Group, Inc.	Appraisal fees	4,000
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(9,431)
Reclassifications		
McCracken, Walsh, DeLavan & Hetler	Legal	(9,130)
Total, Agrees to Schedule V, Line 19, Column 8		58,073

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Deferred maintenance	Dec-99	$ 2,792	3	$ 465	$ 931	$ 931	$ 465	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,792		$ 465	$ 931	$ 931	$ 465	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Streamwood # 0037002 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,875** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,640**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,165** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **52**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Streamwoo** **03:22 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-990,422	equal to	-990,422	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	348,779	equal to	348,779	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	430,861	equal to	430,861	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	241,162	equal to	241,162	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,697	equal to	6,697	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	642,078	equal to	642,078	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	146,252	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,373,902	equal to	1,373,902	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,453,566	equal to	4,453,566	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,985,880	equal to	1,985,880	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,694,423	equal to	1,694,423	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	333,204	equal to	333,204	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	122,640	equal to	122,640	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,908,560	equal to	3,009,596	-101,036	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	224,184	equal to	224,184	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	77,307	equal to	77,307	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	299,897	equal to	299,897	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	70,669	equal to	70,669	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	255,800	equal to	255,800	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	70,297	equal to	70,297	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	195,967	equal to	195,967	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	477,104	equal to	477,104	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,680,821	equal to	4,680,821	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	15,732	< or = to	15,732	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,500	< or = to	24,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	126,610	< or = to	131,341	-4,731	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,384	< or = to	3,384	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	12,257	< or = to	12,257	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	195,967	equal to	195,967	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	381,460	equal to	381,460	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	52,675	equal to	52,675	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	665,331	equal to	665,331	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	32,547	equal to	32,547	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,544	equal to	6,544	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	122,640	equal to	122,640	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	11,165	< or = to	71,745	-60,580	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	11,165	equal to	11,165	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,655	equal to	11,031	-4,376	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-384,435	equal to	-384,435	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,720,342	equal to	5,720,342	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	462,000	equal to	462,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	229,445	equal to	229,445	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,199,678	equal to	6,199,678	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	818,521	equal to	818,521	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,444,574	equal to	2,444,574	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	356,204	equal to	356,204	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-566,978	equal to	-566,978	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,845,320	equal to	2,845,320	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	299,897	29,039	15,732	344,668	0	344,668	0	344,668
2. Food P	0	255,574	0	255,574	0	255,574	-11,217	244,357
3. Housek	255,800	42,446	0	298,246	0	298,246	771	299,017
4. Laundry	70,297	24,093	0	94,390	0	94,390	-5,392	88,998
5. Heat ar	0	0	192,264	192,264	0	192,264	4,117	196,381
6. Mainter	70,669	0	118,091	188,760	0	188,760	1,599	190,359
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	696,663	351,152	326,087	1,373,902	0	1,373,902	-10,122	1,363,780
9. Medical	0	0	24,500	24,500	0	24,500	0	24,500
10. Nursin	3,009,596	314,690	131,341	3,455,627	0	3,455,627	0	3,455,627
10a. Ther	0	0	642,078	642,078	0	642,078	0	642,078
11. Activit	224,184	14,229	3,384	241,797	0	241,797	0	241,797
12. Social	77,307	0	12,257	89,564	0	89,564	0	89,564
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	3,311,087	328,919	813,560	4,453,566	0	4,453,566	0	4,453,566
17. Admin	195,967	0	381,460	577,427	0	577,427	-381,460	195,967
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	52,675	52,675	0	52,675	5,398	58,073
20. Fees,	0	0	31,368	31,368	0	31,368	1,179	32,547
21. Clerica	477,104	36,420	38,539	552,063	0	552,063	14,681	566,744
22. Emplo	0	0	593,586	593,586	0	593,586	71,745	665,331
23. Inserv	0	0	738	738	0	738	0	738
24. Travel	0	0	3,312	3,312	0	3,312	3,232	6,544
25. Other	0	0	0	0	0	0	10,600	10,600
26. Insura	0	0	174,711	174,711	0	174,711	3,522	178,233
27. Other	0	0	0	0	0	0	0	0
28. Total (	673,071	36,420	1,276,389	1,985,880	0	1,985,880	-271,103	1,714,777
29. Total (	4,680,821	716,491	2,416,036	7,813,348	0	7,813,348	-281,225	7,532,123
30. Depre	0	0	57,482	57,482	0	57,482	183,680	241,162
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	15,695	15,695	0	15,695	333,084	348,779
33. Real E	0	0	0	0	0	0	430,861	430,861
34. Rent -	0	0	1,619,417	1,619,417	0	1,619,417	########	0
35. Rent -	0	0	1,829	1,829	0	1,829	4,868	6,697
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	1,694,423	1,694,423	0	1,694,423	-666,924	1,027,499
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	146,252	117,169	263,421	0	263,421	0	263,421
40. Barbe	0	0	18,195	18,195	0	18,195	0	18,195
41. Coffee	0	0	9,315	9,315	0	9,315	0	9,315
42. Provid	0	0	122,640	122,640	0	122,640	0	122,640
43. Other	0	0	42,273	42,273	0	42,273	-42,273	0
44. Total S	0	146,252	309,592	455,844	0	455,844	-42,273	413,571
45. Grand	4,680,821	862,743	4,420,051	9,963,615	0	9,963,615	-990,422	8,973,193

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	113,055	140,032
2. Cash - F	0	0
3. Account	1,994,084	1,994,084
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	63,915	63,915
7. Other Pr	0	0
8. Account	69,032	68,039
9. Other (s	0	0
10. Total c	2,240,086	2,266,070
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	56,718	56,718
13. Land	0	229,445
14. Buildin	0	5,353,558
15. Leasel	547,676	846,120
16. Equipn	222,614	818,521
17. Accum	-221,774	########
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	0	92,967
24. Total L	605,234	4,952,755
25. Total A	2,845,320	7,218,825
CURRENT LIABILITIES		
26. Accour	311,367	311,367
27. Officer'	0	0
28. Accour	439,997	439,997
29. Short-T	391,592	391,592
30. Accrue	319,724	319,724
31. Accrue	1,999	1,999
32. Accrue	0	462,000
33. Accrue	0	40,964
34. Deferre	0	0
35. Federa	0	0
36. Other (	724,437	93,075
37. Other (	0	0
38. Total C	2,189,116	2,060,718
LONG TERM LIABILITES		
39.Long-Te	300,000	300,000
40.Mortgag	0	5,028,750
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	526,466
44.Other L	0	0
45.Total Lo	300,000	5,855,216
46.Total Li	2,489,116	7,915,934
47.Total Eq	356,204	-697,109
48.Total Li	2,845,320	7,218,825

		Balance per Medicaid Trial Balance
1.	Gross F	8,421,581
2.	Discour	-481,579
	Subtota	7,940,002
4.	Day Ca	0
5.	Other C	0
6.	Therapy	1,092,202
7.	Oxygen	2,639
	Subtota	1,094,841
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	10,022
13.	Barber	21,945
14.	Non-P	52
15.	Teleph	91
16.	Rental	0
17.	Sale o	206,886
18.	Sale o	0
19.	Labora	29,302
20.	Radiol	8,294
21.	Other	75,973
22.	Laund	5,392
	Subtot	357,957
24.	Contril	0
25.	Interes	480
	Subtot	480
27.	Other	3,357
28.	Other	0
	Subtot	3,357
30.	Total F	9,396,637
31.	Gener	1,373,902
32.	Health	4,453,566
33.	Gener	1,985,880
34.	Owner	1,694,423
35.	Specia	333,204
35.	Provid	122,640
37.	Other	0
40.	Total E	9,963,615
41.	Incom	-566,978
42.	Incom	0
43.	Net In	-566,978

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Line 16 for mortgage insurance.